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In The

Supreme Court of the United States

October Term, 1994

AUTO-OWNERS INSURANCE COMPANY,

Petitioner,

vs.

THORN APPLE VALLEY, INC.,

Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Where a coordination of benefits clause in a private contract of insurance comes into conflict with an opposing coordination of benefits clause contained in an employee benefit plan, does the federal common law under ERISA resolve the impasse by "preempting" (invalidating) the private insurer's clause, such that the ERISA plan's clause is given full force and effect (rendering its coverage secondary to the insurer's); or does the federal common law resolve the impasse by according equal validity to the competing clauses, recognizing them as mutually exclusive, and dictating that primary responsibility for the mutually covered loss is shared equally between the two coverage providers?

PARTIES TO THE PROCEEDING AND RULE 29.1 STATEMENT

Auto-Owners Insurance Company brought this action as plaintiff against Defendant, Thorn Apple Valley, Inc., Respondent herein. Chris L. Shattuck was also named as a defendant in the original state court complaint, but solely as an interested party as the individual whose benefits are the subject of this priority of coverage dispute. He did not participate or appear in any stage of this litigation.

Petitioner, Auto-Owners Insurance Company, is not a subsidiary of any parent corporation, and has no subsidiary companies that are not wholly-owned.

TABLE OF CONTENTS

	Page
Question Presented for Review	i
Parties to the Proceeding and Rule 29.1 Statement	ii
Table of Contents	iii
Table of Citations	iv
Opinions Below	1
Statement of Jurisdiction	2
Statutory Provisions Involved	2
Statement of the Case	3
A. Factual Background	3
B. Proceedings Below	5
Reasons for Granting the Writ	9
I. Despite the need for uniformity of federal ERISA law, the court of appeals' holding in this case is inconsistent with previous decisions of the Sixth Circuit and in direct conflict with decisions of the Seventh Circuit and other jurisdictions.	10
II. The court of appeals misapplied the principle of ERISA "preemption" to the terms of a plan COB provision, and created a rule of law specifically adverse to the interests of plan participants and beneficiaries.	16
Conclusion	24

Contents

Page

TABLE OF CITATIONS

Cases Cited:

Auto Club Ins. Assoc. v. Health & Welfare Plans, Inc., 961 F.2d 588 (6th Cir. 1992) 6, 7, 8, 10, 11, 12, 15, 19

Blue Cross and Blue Shield of Kansas, Inc. v. Riverside Hospital, 237 Kan. 829, 703 P.2d 1384 (1985) 11, 12, 13

Chemung Canal Trust Company v. Sovran Bank/ Maryland, 939 F.2d 12 (2d Cir. 1991) 17

D'Oench, Duhme & Co., Inc., v. Federal Deposit Insurance Corporation, 315 U.S. 447 (1942) 2

Federal Kemper Ins. Assoc. v. Health Ins. Admin., Inc., 424 Mich. 537, 383 N.W. 2d 590 (1986) 6, 10, 11, 19, 20

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) 2

FMC Corp. v. Holliday, 498 U.S. 52 (1990) 6, 11, 19

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990) .. 19

Inter Valley Health Plan v. Blue Cross/Blue Shield of Connecticut, 16 Cal. App. 4th 60, 19 Cal. Rptr. 2d 782 (1993), *cert. denied*, __ U.S. __, 114 S. Ct. 881 (1994) 14, 15

Contents

Page

Kentucky Laborers Health & Welfare Fund v. Hope, 861 F.2d 1003 (6th Cir. 1988) 8

Liberty Mutual Ins. Group v. Iron Workers Health Fund, 879 F.2d 1384 (6th Cir. 1989) 23

Lincoln Mutual Casualty Co. v. Lectron Products, Inc., 970 F.2d 206 (6th Cir. 1992) 6, 7, 10, 15

Mackey v. Lanier Collections Agency & Service, Inc., 486 U.S. 825 (1988) 17

Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985) 16

Metropolitan Life Insurance Co. v. Taylor, 481 U.S. 58 (1987) 6

Northeast Dept. ILGWU v. Teamsters Local Union No. 229, 764 F.2d 147 (3rd Cir. 1985) 13, 14

Northern Group Services, Inc. v. Auto-Owners Ins. Co., 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988) 11

Pacific Indemnity Co. v. Fireman's Fund Insurance Co., 175 Cal. App. 3rd 1191, 223 Cal. Rptr. 312 (1985) 17, 18

Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987) . 2

PM Group Life v. Western Growers Assurance Trust, 953 F.2d 543 (9th Cir. 1992) 14

Contents

Page

Singer v. Black & Decker Corp., 964 F.2d 1449 (4th Cir. 1992) 9

Starks v. Hospital Service Plan of N.J., Inc., 182 N.J. Super. 342, 440 A.2d 1353 (1981), *aff'd*, 91 N.J. 433, 453 A.2d 159 (1982) 12

St. Paul Fire & Marine Ins. Co. v. American Home Assur. Co., 444 Mich. 560, 514 N.W. 2d 113 (1994) 12

Wahl v. Northern Telecom, Inc., 726 F. Supp. 235 (E.D. Wisc. 1989) 21, 22

Wayne Chemical, Inc. v. Columbia Agency Service Corp., 426 F. Supp. 316 (N.D. Ind.), *modified on other grounds*, 567 F.2d 692 (7th Cir. 1977) 16

Whitworth Bros. Storage Co. v. Central States Fund, 794 F.2d 221 (6th Cir.), *cert. denied*, 479 U.S. 1007 (1986) 8

Winstead v. Indiana Insurance Co., 855 F.2d 430 (7th Cir. 1988), *cert. denied*, 488 U.S. 1030 (1989) 7, 8, 10, 11, 12, 14, 15, 18, 19, 20

Statutes Cited:

28 U.S.C. § 1254(1) 2

28 U.S.C. § 1331 6

29 U.S.C. § 1001, *et seq.* 2

Contents

Page

29 U.S.C. § 1001(b) 21

29 U.S.C. § 1144 ..... 2, 3, 19

Mich. Comp. Laws § 500. 3109a, Mich. Stat. Ann. § 24.13109(1) 6

Rule Cited:

Sixth Circuit Local Rule 14(a) 2

Other Authority Cited:

16 *Couch on Insurance*, 2d, § 62:79 (Lawyers Co-Op. 1983) 12, 13

APPENDIX

Appendix A — Order of the United States Court of Appeals for the Sixth Circuit Filed September 26, 1994 .. 1a

Appendix B — Opinion and Order of the United States Court of Appeals for the Sixth Circuit Filed August 1, 1994 ..... 3a

Appendix C — Opinion and Order of the United States District Court for the Western District of Michigan, Southern Division Dated April 12, 1993 ..... 14a

No.

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PETITION FOR A WRIT OF CERTIORARI

Auto-Owners Insurance Company respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 3a-11a) is reported. *Auto-Owners Insurance Company v. Thorn Apple Valley, Inc.*, 31 F.3d 371 (6th Cir. 1994). The opinion of the district court (App., *infra*, 14a-25a) is also reported. *Auto-Owners Insurance Company v. Thorn Apple Valley*, 818 F. Supp. 1078 (W.D. Mich. 1993).

STATEMENT OF JURISDICTION

The judgment of the court of appeals was entered on August 1, 1994, and was followed by a timely filed motion for rehearing and petition for rehearing en banc (*see* Sixth Circuit Local Rule 14(a)). The motion for rehearing was denied by order of September 26, 1994, and a petition for writ of certiorari is due on December 25, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This matter arises under the Employment Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq.* Because no provision in ERISA addresses the specific question presented, this case involves the federal common law under ERISA. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 56 (1987). *See D'Oench, Duhme & Co., Inc., v. Federal Deposit Insurance Corporation*, 315 U.S. 447, 465-475 (1942) (Jackson, J., concurring).

The court of appeals based its decision on "the preemptive effect of ERISA" (App., *infra*, 10a). The preemption provision, § 514 of ERISA, 29 U.S.C. § 1144, provides in pertinent part:

> **§ 1144. OTHER LAWS**
>
> (a) *Supersedure; effective date*
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any

employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) *Construction and application*

* * *

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

STATEMENT OF THE CASE

A. Factual Background

The facts which give rise to the legal question presented are not in dispute. On June 18, 1989, Chris Shattuck was injured in an

automobile accident and as a result incurred extensive medical expenses. He was covered as an insured under his father's no-fault automobile insurance policy issued by Petitioner, Auto-Owners Insurance Company (Court of Appeals Appendix ["C.A. App."], 5, ¶6; *id.*, at 14, n. 1). The automobile policy included coverage for personal injury protection benefits (medical expenses), but only "to the extent that same are in excess of coverage for expenses provided under any individual or group health care coverage plan", such as the coverage provided by the employee benefit plan of Respondent, Thorn Apple Valley, Inc. (*id.*).

Shattuck also was covered under his father's participation in Respondent's ERISA-qualified employee benefit plan (C.A. App., 14). As such, he enjoyed comprehensive, primary health coverage, except that the plan also contained a coordination clause, as follows:

> COORDINATION OF BENEFITS
>
> In addition to the benefits payable under this Plan, sometimes an employee or dependent is entitled to benefits for the same hospital or medical expenses under Group Fault or No-Fault Auto Insurance, Individual No-Fault Auto Insurance, Motorcycle Insurance, Medicare or another group plan. Should this type of duplication occur, the insurance does not apply to any liability for losses covered by a primary contributory, excess, secondary or any other coverage of any other basis by any other insurance company, under any other types of circumstances, particularly such benefits as may be payable under any type of coordinating policy with an automobile

> insurance carrier for first party benefits under MCLA 500.3109, et seq.

(C.A. App., 26).[1]

At the time of his accident, then, Chris Shattuck was covered by a no-fault insurance policy whose personal injury protection coverage was expressly secondary to any general health coverage plan, and was also covered by Respondent's comprehensive health coverage plan which was expressly coordinated with any benefits "as may be payable" under any Michigan no-fault insurance coverage.

After the accident, claims for medical expense benefits were submitted both to Petitioner and Respondent. Respondent, relying upon its coordination of benefits clause, denied payment. Petitioner, in order to ensure that Shattuck's expenses did not remain unpaid, made full payment of all outstanding expenses and brought this declaratory action to recoup the monies it had paid and seeking a declaration with regard to the parties' responsibilities for future expenses.

B. Proceedings Below

On August 12, 1992, Petitioner filed this case in the

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1. Quoting the Thorn Apple Valley coordination of benefits clause, the court of appeals stated:

> As this language makes clear, the TAV plan was in direct conflict with the Auto Owners policy with respect to coordination of benefits; both the plan and the policy purported to make the other primarily liable for payment of medical expenses.

(App., *infra*, 5a).

Michigan Circuit Court for Ionia County seeking declaratory relief and reimbursement for the medical expenses it had paid. Asserting federal question jurisdiction, Respondent removed the case to the United States District Court for the Western District of Michigan. 28 U.S.C. § 1331; *see Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987).

In lieu of responsive pleadings, Respondent filed a motion to dismiss and/or for summary judgment based upon its contention that any relief under state law was preempted by ERISA, and ERISA itself provided no relief for Petitioner. In its responsive brief, Petitioner cross-moved for summary judgment in its favor, asserting that the federal common law of ERISA provided the relief sought.

The district court denied Respondent's motion and granted summary judgment in favor of Petitioner (App., *infra*, 14a-26a). In its opinion of April 12, 1993, the court first held that the solution to this coverage priority dispute under Michigan law[2] was inapplicable due to ERISA preemption (*id.*, at 18a-19a), a point conceded by Petitioner in light of *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), *Auto Club Ins. Assoc. v. Health & Welfare Plans, Inc.*, 961 F.2d 588, 592-593 (6th Cir. 1992), and *Lincoln*

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2. In Michigan, no-fault automobile insurers are statutorily required to "offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured." Mich. Comp. Laws § 500.3109a; Mich. Stat. Ann. § 24.13109(1). In order to effectuate this mandated reduction in premiums, the Michigan Supreme Court held in *Federal Kemper Ins. Assoc. v. Health Ins. Admin., Inc.*, 424 Mich. 537, 383 N.W. 2d 590 (1986), that primary liability falls on the health insurer when a conflict exists between the COB clauses of a no-fault insurance policy and another provider of health and accident coverage. *See Auto Club Ins. Assoc. v. Health & Welfare Plans, Inc.*, 961 F.2d 588, 590 n. 3 (6th Cir. 1992); *Lincoln Mutual Casualty Co. v. Lectron Products, Inc.*, 970 F.2d 206, 208 n. 2 (6th Cir. 1992).

Mutual Casualty Co. v. Lectron Products, Inc., 970 F.2d 206, 209-210 (6th Cir. 1992) (*id.*).

The court then proceeded to reject Respondent's position that a finding of ERISA preemption puts an end to the inquiry. Following the Sixth Circuit's suggestion in *Auto Club Ins. Assoc.*, 961 F.2d at 594-595 and *Lincoln Mutual*, 970 F.2d at 211, the district court applied the Seventh Circuit's analysis and holding in *Winstead v. Indiana Insurance Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, 488 U.S. 1030 (1989). It recognized that both coverage providers in this case purported to be secondary due to the presence of the other, and that "the ERISA statute itself does not provide an answer." The district court thus looked to prevailing state law methods for resolving priority of coverage conflicts, and held as a matter of federal common law that the primary liability for Shattuck's medical expenses must be shared equally between the two parties (App., *infra*, 19a-24a):

> Accordingly, this Court adopts the following rule as the appropriate coordination of benefits rule under ERISA: When there is a conflict between two unambiguous, valid, and irreconcilable "other insurance" or coordination of benefits provisions in an ERISA plan and a non-ERISA insurer, such as a Michigan no-fault insurer, the coverage responsibility must be apportioned between the insurers on a *pro rata* basis.

(App., *infra*, 24a).

The court of appeals reversed (App., *infra*, 3a-11a). Initially, the court rejected Respondent's principal contention (Appellant's Brief to the Court of Appeals, pp. 9-17) that the

absence of an express or implied statutory cause of action in ERISA foreclosed any jurisdictional basis for Petitioner's claim, finding such a basis in federal common law (App., *infra*, 7a-8a) (citing, *Kentucky Laborers Health & Welfare Fund v. Hope*, 861 F.2d 1003, 1005 (6th Cir. 1988), and *Whitworth Bros. Storage Co. v. Central States Fund*, 794 F.2d 221 (6th Cir.), *cert. denied*, 479 U.S. 1007 (1986). Furthermore, the court noted that, while the Michigan law that would have resolved the priority of coverage conflict in favor of the no-fault insurer was preempted, such preemption " 'does not, we reiterate, render the [no-fault insurer's] coordination of benefits clause *ipso facto* void.' " (App., *infra*, 9a, quoting *Auto Club*, 961 F.2d at 593).

The court nevertheless proceeded to hold that the ERISA plan's coordination of benefits clause must prevail, effectively rendering void the opposing clause in the private insurance contract (App., *infra*, 7a — "we conclude that when a traditional insurance policy and a qualified ERISA plan contain conflicting coordination of benefits clauses, the terms of the ERISA plan, including its COB clause, must be given full effect"). The brief statement of federal policy given in support of its decision was ERISA's purpose of protecting the interests of plan participants and beneficiaries (*id.*, at 10a): "In our view, this directive means that Congress sought to guard qualified benefit plans from claims . . . which have been expressly disavowed by the plans."

The court concluded by determining that private insurers and ERISA benefit plans do not litigate on a level "playing field" (*id.*, at 10a). Explicitly rejecting the contrary decision of the Seventh Circuit in *Winstead*, the court of appeals posited that the two coordination of benefits clauses do not compete equally because the COB clause in the plan "is bolstered by the preemptive effect of ERISA."

REASONS FOR GRANTING THE WRIT

This case presents an important and recurring question of federal law under ERISA. As coverage providers of all types endeavor to minimize costs and prevent payment of needlessly duplicative benefits, disputes over conflicting coordination of benefits clauses between private insurers and ERISA-qualified plans are increasingly common. Because the ERISA statute itself provides no coordination of benefits rule, an appropriate *and uniform* rule of federal common law is needed. As the Fourth Circuit recently observed, the "federal common law [of ERISA] should be consistent across the circuits. To the extent that inconsistencies arise, Congress and the Supreme Court are capable of harmonizing them." *Singer v. Black & Decker Corp.*, 964 F.2d 1449, 1453 (4th Cir. 1992). The degree of inconsistency among the courts being faced with these disputes now requires Supreme Court review.

The decision of the court of appeals is also fundamentally flawed. First, the court extended the notion of "ERISA preemption" beyond displacement of state *law* to the point of giving preemptive force to plan provisions themselves such that perfectly valid *clauses* in private insurance *contracts* are "preempted." Second, while the court purported to be protecting the interests of plan participants and their beneficiaries (App., *infra*, 7a), in fact the court protected only the plan *itself* by insulating it from a claim where coverage exists. The holding is inimical to the interests of covered participants and beneficiaries.

I.

DESPITE THE NEED FOR UNIFORMITY OF FEDERAL ERISA LAW, THE COURT OF APPEALS' HOLDING IN THIS CASE IS INCONSISTENT WITH PREVIOUS DECISIONS OF THE SIXTH CIRCUIT AND IN DIRECT CONFLICT WITH DECISIONS OF THE SEVENTH CIRCUIT AND OTHER JURISDICTIONS.

This case raises the question of how to reconcile priority of coverage disputes where both parties would provide primary coverage of the loss but for their mutually exclusive coordination of benefits clauses. Expressly rejecting the holding of the Seventh Circuit in *Winstead v. Indiana Insurance Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, 488 U.S. 1030 (1989), and despite its own recent precedent establishing that ERISA preemption does not render a private insurer's COB clause void (*Auto Club*, 961 F.2d at 593; *Lincoln Mutual*, 970 F.2d at 211), the court of appeals below held that the coordination of benefits (COB) clause of a qualified ERISA plan is to be given full effect, to the detriment of a private insurer whose coverage is subject to an equally valid coordination of benefits clause.

The *Winstead* court had addressed virtually the same set of facts, except that it was the ERISA plan that initially paid the accident victim's medical costs and then sought reimbursement from the automobile insurer. Both carriers had COB provisions to the effect that any other coverage would be primarily liable for the expenses. The automobile insurer claimed that Michigan's special rule announced in *Federal Kemper Ins. Co. v. Health Ins. Admin.*, 424 Mich. 537; 383 N.W.2d 590 (1986)[3], should apply to render the Fund's coverage primary. In response, the Fund argued not only that the *Federal Kemper* rule could not be imposed upon

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3. *See* n. 2, *supra*.

an ERISA plan, but that "federal ERISA law preempts the Indiana Insurance *policy.*" It argued that, to the extent that the insurer's provisions conflicted with its own of coverage, "the terms and condition of the Fund policy must be enforced." *Winstead*, 855 F.2d at 433 (emphasis added).

The Seventh Circuit rejected the plan's notion of ERISA preemption. While agreeing that application of Michigan's *Federal Kemper* rule was preempted[4], it could not accept the suggestion that a provision in the accident victim's insurance contract was encompassed within the scope of ERISA preemption and thereby rendered unenforceable. Instead, the court accorded equal validity to the parties' competing COB clauses, found them to be mutually repugnant and, guided by rules traditionally applied in contract interpretation for reconciling COB clauses, established the federal common law rule that both carriers would share primary responsibility on a pro rata basis. 855 F.2d at 433-434.

The Supreme Court of Kansas likewise has rejected the argument that the COB clause of an ERISA benefit plan must prevail over the competing COB clause of a private insurer's contract. In *Blue Cross and Blue Shield of Kansas, Inc. v. Riverside Hospital*, 237 Kan. 829, 703 P.2d 1384 (1985), a private

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4. In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), this Court broadly construed the preemption provisions of ERISA to hold that qualified plans could not be subject to state laws that regulate insurance, effectively overruling *Northern Group Services, Inc., v. Auto-Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988). *See Auto Club Ins. Assoc. v. Health & Welfare Plans, Inc.*, 961 F.2d at 592-593. In *Winstead*, the Seventh Circuit did not apply the *Northern Group Services* analysis. Thus, although it pre-dated *FMC*, *Winstead* is entirely consistent with and in fact foreshadowed the state of the law post-*FMC*. *See Auto Club*, 961 F.2d at 595 n. 14. Respondent has conceded that the case at bar is "essentially identical" to *Winstead* (Appellant's Brief to the Court of Appeals, p. 2).

insurer paid benefits then sought reimbursement from an employee benefit plan. The court examined the language of the competing COB clauses and, applying traditional methods for discerning the intent of the respective coverage providers[5], held

5. Courts generally follow one of two approaches to resolve the conflict that arises when two coordinated coverages clash over a given loss. The so-called "majority rule" requires the court to examine the competing clauses to discern the intent of the respective coverage providers based on whether they utilized "escape", "excess" or "pro rata" coordination language, and attempt to reconcile the apparent intentions. The so-called "minority rule" posits that such analysis ultimately is circular, dependent on which policy is read first. Under the minority approach, opposing COB clauses are deemed to be mutually repugnant regardless of their specific types, and the loss is equally apportioned between the carriers to the extent of their duplicative coverage. Even under the "majority rule," however, the opposing clauses frequently are found to be irreconcilable with the result that primary responsibility is shared equally between the parties. *See St. Paul Fire & Marine Ins. Co. v. American Home Assur. Co.*, 444 Mich. 560, 565-577, 514 N.W.2d 113 (1994), and cases cited therein; *Blue Cross and Blue Shield of Kansas, Inc. v. Riverside Hospital*, 703 P.2d at 1388-91; *Starks v. Hospital Service Plan of N. J., Inc.*, 182 N.J. Super. 342; 440 A.2d 1353, 1359 (1981), *aff'd*, 91 N.J. 433, 453 A.2d 159 (1982). There is a "growing tendency" toward rejecting the "circular reasoning" of the majority rule. 16 *Couch on Insurance*, 2d, § 62:79, p. 550 (Lawyers Co-Op. 1983); *Auto Club*, 961 F.2d at 595 n. 13 (minority view now referred to as a " 'popular approach[ ]' ").

Because the Sixth Circuit appeared to endorse the so-called minority approach adopted in *Winstead* (*Auto Club*, at 594-595), and because of its practical simplicity, Petitioner has advocated only that approach in this case. **If the "majority rule" were applied, however, Respondent's coverage would be primary and Petitioner's only secondary.** Respondent's COB is an "escape" clause, such that the plan *normally* provides full, primary health coverage with the *exception* turning on whether there is coverage that is "payable" causing "duplication [to] occur" (Respondent's COB clause, quoted *supra*, at pp. 4-5). Petitioner's no-fault insurance policy, on the other hand, while providing collision, liability, and other such coverages, *normally* does not provide medical benefits (a reduced premium was paid just for this reason),

(Cont'd)

that the private insurer was secondary and the ERISA plan was primary. The defendant had "contend[ed], in essence, that by virtue of its plan being rooted in ERISA, it is placed in an unassailable position when challenged by a plan [private insurer] rooted in state law." 703 P.2d at 1388. The court rejected this notion: "The fact that the Riverside plan is rooted in ERISA is not, we believe, a significant factor in the determination of the issue before us. Therefore, the matter of preemption is not involved herein" (*id.*).

The Kansas Supreme Court stated that its holding was "consistent with the rationale expressed in *Northeast Dept. ILGWU v. Teamsters Local Union No. 229*, 764 F.2d 147 (3rd Cir. 1985)." 703 P.2d at 1390. In *ILGWU*, the Third Circuit addressed a conflict between one plan's escape clause and another plan's excess clause, the types of COB clauses present in the case at bar.[6] Determining that the competing clauses could not be harmonized by their respective intents ("each plan provides primary coverage unless the other plan provides primary coverage" — 764 F.2d at 161), the court looked to prevailing rules of state common law (*id.*, at 162-163) as an appropriate basis for federal common law under ERISA. Because escape clauses are disfavored and generally not enforced as against excess clauses, which are more compatible with the interests of the insured, the Third Circuit held: "escape clauses in ERISA covered employee benefit plans are unenforceable as a matter of law." *Id.*, at 164. Were this

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(Cont'd)
except on an "excess" basis. Primary coverage thus is not "payable" and there is no "duplication." 16 *Couch on Insurance*, 2d, §62:77, p. 543 ("Where one of the policies contains an excess insurance clause and the other contains a no-liability [escape] clause, the conflict has been resolved in the greatest number of cases by imposing liability on the insurer issuing the policy containing the no-liability clause").

6. *See supra*, n. 5.

holding applied to the case at bar, Respondent's escape clause would be unenforceable and Petitioner's excess COB clause would render the no-fault coverage secondary.[7]

This manifest *lack* of uniformity among ERISA coordination of benefits cases recently prompted the California Court of Appeals to throw up its hands and apply its own *state* law to an ERISA coverage dispute. In *Inter Valley Health Plan v. Blue Cross/Blue Shield of Connecticut*, 16 Cal. App. 4th 60, 19 Cal. Rptr. 2d 782 (1993), *cert. denied*, __ U.S. __, 114 S. Ct. 881 (1994), the court noted that the Ninth Circuit had endorsed the "birthday rule" as an appropriate ERISA coordination rule in *PM Group Life Ins. Co. v. Western Growers Assurance Trust*, 953 F.2d 543 (9th Cir. 1992). The California court, however, refused to follow *PM Group Life* due in part to a factual distinction (divorced/non-divorced parents), but primarily due to the lack of a uniform rule:

> Reasoning from the broad preemption provision in ERISA, the *PM Group Life* court focused primarily on the need to adopt a *uniform* federal rule under ERISA[.]. . .
>
> These considerations are not persuasive here. First, *federal law is not uniform, and is not going to be uniform until the United States Supreme Court finally decides the matter. PM Group Life* does not appear to have been

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7. The Third Circuit's holding was reached in the context of a dispute between two ERISA plans, but the court nowhere suggested that the holding was limited to such circumstances. *ILGWU*, 764 F.2d at 164. Again, Petitioner has not advocated avoidance of Respondent's COB clause, but rather the Seventh Circuit's *Winstead* rule that accords equal validity to the competing clauses. *See supra*, n. 5. *Also see Winstead*, 855 F.2d at 434, discussing *ILGWU*.

> aware of cases from the Sixth and Seventh Circuits which adopted an approach altogether different from the birthday rule. (See *Auto Club Ins. v. Health and Welfare Plans* (6th Cir.1992) 961 F.2d 588, 594-595; *Winstead v. Indiana Ins. Co.*, (7th Cir.1988) 855 F.2d 430, 433-434.

Inter Valley, 19 Cal. Rptr. 2d at 786 (emphasis added).

As the above indicates, the California court viewed the Sixth Circuit as already having endorsed *Winstead*'s equal apportionment of primary liability. In rejecting this common sense approach in favor of one which renders the COB clauses of private insurers inferior to those of ERISA plans, the court of appeals thus not only has thrown yet another "rule" into the mix, but has tacitly contravened its own previous holdings that "ERISA preemption" does *not* invalidate a private insurer's competing, irreconcilable COB clause. *Auto Club*, 961 F.2d at 592-593; *Lincoln Mutual*, 970 F.2d at 211.

ERISA was intended to provide a single, uniform body of federal law to govern disputes involving qualified employee welfare benefit plans. The conflict now existing among the circuits in their approaches to resolving ERISA coverage priority disputes frustrates this purpose. Further review is warranted.

II.

THE COURT OF APPEALS MISAPPLIED THE PRINCIPLE OF ERISA "PREEMPTION" TO THE TERMS OF A PLAN COB PROVISION, AND CREATED A RULE OF LAW SPECIFICALLY ADVERSE TO THE INTERESTS OF PLAN PARTICIPANTS AND BENEFICIARIES.

1. This case presents a dispute between two providers of medical expense coverage with valid COB clauses that create a logical impasse: both cannot be secondary. The dispute is controlled by ERISA, but ERISA itself contains no coordination of benefits rule. Contrary to the approach taken by the court of appeals, the solution to the problem is not found in blurry notions of "the preemptive effect of ERISA" but in federal common law fashioned after equitable solutions developed by the states. As Justice Brennan observed in *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S.134, 157 n. 18 (1985) (Brennan, J., concurring) (quoting *Wayne Chemical, Inc. v. Columbia Agency Service Corp.*, 426 F. Supp. 316, 325 (N.D. Ind.), *modified on other grounds*, 567 F.2d 692 (7th Cir. 1977):

> "Where the courts are required themselves to fashion a federal rule of decision, the source of that law must be federal and uniform. Yet, state law where compatible with national policy may be resorted to and adopted as a federal rule of decision. . . . Here, of course, there is little federal law to which the court may turn for guidance. State regulation of insurance, pensions, and other such programs, however, provides a pre-existing source of experience and experiment in an area in which there is, as yet, only federal inexperience."

In *Chemung Canal Trust Company v. Sovran Bank/ Maryland*, 939 F.2d 12 (2d Cir. 1991), the Second Circuit recognized in ERISA a federal common law remedy of indemnity and contribution. The court emphasized that it was not creating a right from whole cloth. Rather, "[w]e are simply following the legislative directive to fashion, where congress has not spoken, a federal common law for ERISA by incorporating what has long been embedded in traditional trust law and equity jurisprudence." *Id.*, at 16. Pursuant to the same legislative directive, the rule announced in *Winstead* is indeed "in keeping with generally accepted notions derived from state common law [and is] eminently fair and equitable." 855 F.2d at 434.

Thus it is just and equitable that the coverage provider who steps forward and protects the interests of the covered individual should receive reimbursement from the co-primary coverage provider in accordance with and to the extent of the other's liability on an equal share basis. In rejecting the "fair and equitable" solution espoused by the Seventh Circuit in favor of a rule which relegates private insurance contracts to second class status, the court of appeals erred.

Congress did not intend to create a fully insulated legal world around ERISA benefit plans. *See Mackey v. Lanier Collections Agency & Service, Inc.*, 486 U.S. 825, 833 (1988). Rather, coverage conflicts between plans and other insurers should be resolved in accordance with well recognized principles that govern "the reciprocal rights and duties of several insurers who have covered the same event." *Pacific Indemnity Co. v. Fireman's Fund Insurance Co.*, 175 Cal. App. 3rd 1191, 1197; 223 Cal. Rptr. 312, 315 (1985). The California court described the coverage relationship as follows:

> "The reciprocal rights and duties of several insurers who have covered the same event do

> not arise out of contract, for their agreements are not with each other. . . Their respective obligations flow from equitable principles designed to accomplish ultimate justice in the bearing of a specific burden. As these principles do not stem from agreement between the insurers their application is not controlled by the language of their contracts with the respective policy holders." . . . [Quoting *Signal Companies, Inc. v. Harbor Ins. Co.*, 27 Cal.3d 359, 369; 165 Cal. Rptr. 799; 612 P.2d 889 (1980).]
>
> Thus, Signal once again reaffirms the well recognized principle that the rights and duties of several insurers who have covered the same event but have not contracted with each other with respect to it, are not the same to one another as they are to their respective insureds. They are, instead, governed by and "flow from equitable principles designed to accomplish ultimate justice in the bearing of a specific burden."

175 Cal. App. 3rd at 1197-98; 223 Cal. Rptr. at 315. The *Winstead* court preserved and applied the "equitable principles" cited above, and the court of appeals even acknowledged in this case that the *Winstead* approach would be "eminently fair" *if* the "playing field" were level (App., *infra*, 10a). The court refused to accord equal legitimacy to the COB clause in the private insurance contract, however, on the basis that "the TAV clause is bolstered by the preemptive effect of ERISA" (*id.*). This reasoning is flawed.

Congress' intent in enacting the ERISA preemption

provisions (29 U.S.C. § 1144) was to ensure that plans and plan sponsors would be subject to a uniform body of benefits law, such that they would not be faced with conflicting or inconsistent State and local regulation of employee benefit plans. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52, 60, 64-65 (1990). This legislative purpose is fully met where, as here, a specific state law such as Michigan's *Federal Kemper* rule is held to be inapplicable to resolve a COB contest between a private insurer and an ERISA plan. Such was the holding of the district court in this case (App., *infra* at 19a), the Sixth Circuit in *Auto Club*, 961 F.2d at 592-593, and the Seventh Circuit in *Winstead*, 855 F.2d at 433.

There is no sound basis, however, for the Sixth Circuit's proposition that "the preemptive effect of ERISA" was intended to "bolster[]" and accord "preemptive" force to whatever coverage priority language appears in a plan when it comes into logical conflict with a perfectly valid coordination of benefits agreement negotiated between a private insurer and its insured.

As the *Winstead* court explained, ERISA preempts *state law*, but it does not void the provisions of private insurance contracts. The court stated:

> [T]he district court rejected the Fund's broad construction of ERISA preemption, explaining that by its own terms ERISA was designed only to supersede "any and all *State laws* insofar as they may now or hereafter relate to any employee benefit plan." (Emphasis supplied.) . . . *We agree* with the conclusion of the district court that *the relevant provision of the Indiana Insurance policy is not rendered void merely as the result of Crampton's concurrent ERISA coverage.*

> The decision to purchase insurance coverage in addition to ERISA coverage featuring an "other insurance" clause is a decision which undoubtedly affects the Fund's potential liability for benefits payments and is, therefore, a decision that "relates to" an ERISA benefits plan. *Id. Crampton's decision to so proceed, however, was a private contractual matter between her and Indiana Insurance;* it was in no way compelled by state law. As the district court properly concluded, nothing in ERISA suggests that individuals are barred from acting as Crampton did in insuring themselves. In fact, the state's ability to facilitate such private choice has been held by the Supreme Court, albeit implicitly, *not* to be preempted by ERISA. See *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 756-58 [ ] (1985). . . . The choice to avail oneself of [a reduced premium, excess-only automobile insurance] policy is strictly a personal one, and thus a matter that ERISA did not intend to preempt.

Winstead, 855 F.2d at 433 (emphasis in original in part, supplied in part).

When the question is properly viewed as a pure issue of priority involving a *valid* COB clause in an ERISA plan and involving an equally *valid* COB clause in a private contract of insurance, and with full recognition that special state rules (such as *Federal Kemper*) are preempted, ERISA provides no basis for a holding that one COB clause is *more* valid than the other.

2. The court of appeals based its conclusion that the playing field is not level (App., *infra*, 10a) on 29 U.S.C. § 1001(b), which defines the purpose of ERISA as protecting "the interests of participants in employee benefit plans and their beneficiaries." The court translated this defined purpose into an obligation to guard the plans (not the beneficiaries) against claims. It erroneously invoked the talisman of "preemption" and deferred to the COB clause in the plan, holding essentially that the terms of the plan will themselves determine the outcome of any dispute involving other coverage contracts. However, as observed by the court in *Wahl v. Northern Telecom, Inc.*, 726 F. Supp. 235 (E.D. Wisc. 1989), this is contrary to the intent of Congress:

> Finding that a self-insured plan is automatically exempt from state insurance regulations, however, does not dictate, as the defendant Northern claims, that the terms of an employee benefit plan are dispositive of the outcome. By preempting state law without providing any federal statute to replace it, Congress intended either (1) to eliminate all regulation of non-core ERISA matters for self-insured plans or (2) to replace the state regulations with federal common law.
>
> * * *
>
> If a court holds that federal common law dictates that the [beneficiary's] rights are determined solely by the employee benefit plan, then it essentially is holding that there is no federal regulation of this area of the law. This outcome, however, does not appear to be what Congress intended. Nowhere in the

> legislative history of ERISA does it appear that Congress wanted to reduce the substantive rights of participants and beneficiaries by allowing self-insured plans to be unregulated. . . .

Id., at 240-241.

Beneficiaries of an "unregulated" plan do not have their interests protected. Further, under the court of appeals' decision, ERISA plan members who drive automobiles will be disadvantaged by a plan's unregulated determination that it will not cover medical expenses incurred in an automobile accident when there is other insurance.

Michigan drivers, like those in most states, are required to purchase automobile insurance for their vehicles if they are to be driven on public roads. Individuals have the option of purchasing policies with full, unqualified medical coverage, or for a substantially reduced premium, electing a policy that coordinates with the insured's general health coverage plan, provided their health coverage plan extends to automobile accident-related expenses. Most Michigan drivers that have other health coverage elect the less expensive excess-only policy.

In the name of "protect[ing] 'the interests of participants in employee benefit plans and their beneficiaries' " (App., *infra*, 10a), the court of appeals has deprived ERISA plan participants and beneficiaries of the right to elect the reduced-premium policy — ***even though their ERISA health plan covers automobile accident-related expenses.*** Respondent's plan members will now be forced to spend substantially more for full-coverage, *non*-coordinated insurance policies despite having comprehensive health coverage that extends to automobile accidents.

There is no dispute that Respondent's beneficiary, Chris Shattuck, enjoyed comprehensive health coverage under the plan and that, furthermore, this coverage extended to any medical expense incurred, whether automobile accident-related or not. The Court should contrast these facts with those in *Liberty Mutual Ins. Group v. Iron Workers Health Fund*, 879 F.2d 1384 (6th Cir. 1989). In that case the insured's health and accident coverage, provided through an ERISA-qualified benefits plan, did *not* cover motor vehicle accidents. The plan contained a clear exclusion, unqualified by any availability of other insurance. Individuals with such limited ERISA plan coverage are compelled to purchase more expensive, full-coverage automobile policies because they have no other applicable coverage with which to coordinate. The situation is fundamentally different, however, where, as here, the individual's ERISA benefits plan *does* cover (does not exclude) motor vehicle accident-related expenses.

To be sure, the plans of this type contain coordination of benefits clauses, with the intent that duplication of payment will be avoided and that the plan members will in no event go uncovered (*see* plan COB clause, *supra* at pp. 4-5). Nevertheless, the distinction between *no* coverage (*Liberty Mutual*) and *coverage* (this case) remains, and is fundamental. The holding reached by the court of appeals erases this distinction, and unnecessarily restricts ERISA plan members' freedom of contract.

CONCLUSION

This matter is of paramount importance not only to ERISA plan members and automobile insurers, but to all types of private insurers whose insureds might also be entitled to benefits under an ERISA plan with coordinated coverage. The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT FILED SEPTEMBER 26, 1994

No. 93-1606

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

ORDER

AUTO OWNERS INSURANCE COMPANY, A MICHIGAN INSURANCE CORPORATION,

Plaintiff-Appellee,

v.

THORN APPLE VALLEY, INC.,

Defendant-Appellant,

CHRIS L. SHATTUCK,

Defendant.

BEFORE: NORRIS and DAUGHTREY, Circuit Judges; and GILMORE,* District Judge.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

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* Hon. Horace W. Gilmore, Senior United States District Judge for the Eastern District of Michigan, sitting by designation.

Appendix A

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT
s/ Leonard Green
Leonard Green, Clerk se

APPENDIX B — OPINION AND ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT FILED AUGUST 1, 1994

No. 93-1606

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

AUTO OWNERS INSURANCE COMPANY, a Michigan insurance corporation,

Plaintiff-Appellee,

v.

THORN APPLE VALLEY, INC.,

Defendant-Appellant.

ON APPEAL from the United States District Court for the Western District of Michigan

Decided and Filed August 1, 1994

Before: NORRIS and DAUGHTREY, Circuit Judges; and GILMORE, Senior District Judge.*

ALAN E. NORRIS, Circuit Judge. This narrowly focused appeal presents a question of federal common law that stems from a dispute between two insurers, one of which qualifies as an employee welfare benefit plan under the Employment

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* The Honorable Horace W. Gilmore, Senior United States District Judge for the Eastern District of Michigan, sitting by designation.

Appendix B

Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. At issue is the extent to which conflicting coordination of benefits ("COB") clauses affect the relative liability of the parties.

I.

Plaintiff, Auto Owners Insurance Company ("Auto Owners"), is a Michigan insurance carrier that issues no-fault automobile insurance policies as pat of its business. Michigan law regulates the terms of such policies. This statutory scheme contains the following provision:

> An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section are subject to prior approval by the commissioner and apply only to benefits payable to the person named in the policy, the spouse of the insured, and any relative of either domiciled in the same household.

Mich. Comp. Laws Ann., § 500.3109a (West 1993). Pursuant to this section, Auto Owners issued a no-fault automobile insurance policy to Joseph Shattuck that included a coordination of benefits clause. This clause provided that Auto Owners, as the no-fault carrier, would be liable to Shattuck for personal injury benefits only to the extent that such benefits were not covered by any health insurance plan he might have.

Appendix B

At the time that his Auto Owners policy was in force, Mr. Shattuck also had health care coverage through his employer, defendant, Thorn Apply Valley, Inc. ("TAV"). Neither party disputes that TAV provided this coverage in the form of an ERISA employee welfare benefit plan, as defined at 29 U.S.C. § 1002(1). Like the Auto Owners policy, the TAV plan contained a coordination of benefits clause:

> In addition to benefits payable under this Plan, sometimes an employee or dependent is entitled to benefits for the same hospital or medical expenses under Group Fault or No-Fault Auto Insurance . . . or another group plan. Should this type of duplication occur, the insurance does not apply to any liability for losses covered by a primary contributory, excess, secondary or any other coverage of any other basis by any other insurance company, under any other types of circumstances, particularly such benefits as may be payable under any type of coordinating policy with an automobile insurance carrier for first party benefits under MCLA 500.3109 et seq.

As this language makes clear, the TAV plan was in direct conflict with the Auto Owners policy with respect to coordination of benefits; both the plan and the policy purported to make the other primarily liable for payment of medical expenses.

This potential conflict became reality when Joseph Shattuck's son, Chris, was injured in an automobile accident on June 18, 1989. Auto Owners paid his medical expenses. When

approached by Auto Owners for reimbursement, the TAV plan declined coverage based upon its COB clause.

As a result, Auto Owners filed a complaint for declaratory relief in Michigan state court, contending that the effect of M.C.L.A. § 500.3109a and the COB clause in its policy was to entitle it to "recoupment" from the TAV plan of the medical expenses paid to Chris Shattuck. TAV subsequently removed the cause to federal district court pursuant to 28 U.S.C. § 1331.

The district court disposed of the case after both parties had submitted motions for summary judgment. In a thoughtful opinion, after reviewing case law in the area and attempting to divine trends in our court, the district court concluded that: "When there is a conflict between two unambiguous, valid, and irreconcilable 'other insurance' or coordination of benefits provisions in an ERISA plan and a non-ERISA insurer, such as a Michigan no-fault insurer, the coverage responsibility must be apportioned between the insurers on a *pro rata* basis." *Auto Owners Ins Co. v. Thorn Apple Valley, Inc.*, 818 F. Supp. 1078, 1083 (W.D.Mich. 1993). Applying this rule, the court then apportioned to each party fifty percent of the liability for Chris Shattuck's medical expenses.

II.

The issue before us has generated a division of opinion from courts that have visited it. On the one hand, the Seventh Circuit has endorsed the pro rata approach advocated by the district court. *Winstead v. Indiana Ins. Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, 488 U.S. 1030 (1989). On the other hand, the Michigan Supreme Court, anticipating the development of federal common law in this circuit, recently held that a no-fault

insurer could not seek payment from an ERISA plan despite a coordination of benefits clause that purported to make the no-fault insurer only secondarily liable for medical expenses. *Auto Club Ins. Ass'n v. Frederick & Herrud, Inc.*, 443 Mich. 358,505 N.W.2d 820 (1993), *cert. denied,* 114 S. Ct. 1300 (1994). The district court did not have this opinion before it, as it was issued several months after the district court's ruling. Although this court has been confronted on at least two occasions with a fact pattern similar to the one now before us, the court has not previously reached the issue. *See Lincoln Mut. Casualty Co. v. Lectron Prods. Inc., Employee Health Benefit Plan,* 970 F.2d 206 (6th Cir. 1992); *Auto Club Ins. Ass'n v. Health and Welfare Plans, Inc.*, 961 F.2d 588 (6th Cir. 1992).

For the reasons outlined below, we conclude that when a traditional insurance policy and a qualified ERISA plan contain conflicting coordination of benefits clauses, the terms of the ERISA plan, including its COB clause, must be given full effect.

A. Jurisdiction

Before reaching the merits of the case, we must first determine whether the district court had jurisdiction. Faced with a nearly identical fact pattern in *Auto Club,* this court found that jurisdiction was proper pursuant to 29 U.S.C. § 1132(a)(1)(B).[1] *Auto Club* at 590. As TAV points out, that section empowers a

1. That section reads as follows:

§ 1132. Civil Enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought —

(Cont'd)

select group of persons — participants or beneficiaries — to bring civil actions. Auto Owners falls into neither of these categories and the company concedes that ERISA contains no provision specifically according it the right to bring a cause of action.

Nonetheless, cases from this circuit have premised jurisdiction on federal common law when the ERISA preemption provision has effectively deprived a plaintiff of a state law claim. *See, e.g., Kentucky Laborers Dist. Council Health and Welfare Fund v. Hope,* 861 F.2d 1003, 1005 (6th Cir. 1988); *Whitworth Bros. Storage Co. v. Central States, Southeast & Southwest Areas Pension Fund,* 794 F.2d 221 (6th Cir.), *cert. denied,* 479 U.S. 1007 (1986). Accordingly, in this circuit, in cases such as this one, where the outcome rests upon the district court's construction of federal common law, jurisdiction is grounded upon 28 U.S.C. § 1331. *Whitworth* at 236.

B. Preemption

Neither party disputes that ERISA preempts M.C.L.A. § 500.3109a. *See Auto Club,* 961 F.2d at 593 (discussing *FMC Corp. v. Holliday,* 498 U.S. 52 (1990)). Thus, the reliance that

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(Cont'd)

> (1) by a participant or beneficiary —
>
> . . . .
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. § 1132 (1988).

plaintiff once placed upon the Michigan statutory scheme governing no-fault automobile insurance has been abandoned.

However, as the opinion in *Auto Club* noted, this consideration does not necessarily mean that the ERISA plan must prevail:

> There still exists here the issue of which of two apparently valid insurance policies containing what would appear to be irreconcilable "other insurance" clauses is liable for payment of [insured's] medical expenses. . . .
>
> . . . .
>
> . . . The fact that, after *FMC*, the Auto Club policy no longer has priority over the [ERISA] Fund plan by virtue of 500.3109a does not, we reiterate, render the Auto Club coordination of benefits clause *ipso facto* void.

Id. Because no federal statute addresses the resolution of the conflict between the COB clauses, application of federal common law is appropriate. *Lincoln Mutual*, 970 F.2d at 211.

C. The Common Law Rule

Since the Supreme Court's landmark *Erie Railroad* decision,[2] development of federal common law has been sharply

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2. *Erie Railroad Co. v. Tompkins*, 304 U.S. 64 (1938).

curtailed. In some contexts, however, it remains a viable source of authority. On occasion, Congress explicitly directs the federal courts to develop a body of common law to fill in the interstices of a statutory scheme in order to ensure national uniformity of application. ERISA presents just such a situation, where federal common law is expected to develop and address rights and obligations arising under the Act. *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 56 (1987); *In re White Farm Equipment Co.,* 788 F.2d 1186, 1191 (6th Cir. 1986).

The underlying purpose of ERISA is to protect "the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(b); *see also Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 113 (1989) (citing *Shaw v. Delta Airlines, Inc.,* 463 U.S. 85, 90 (1983)). In our view, this directive means that Congress sought to guard qualified benefit plans from claims, such as that advanced by Auto Owners, which have been expressly disavowed by the plans.

While we agree that both COB clauses at issue are facially valid, we cannot accept the Seventh Circuit's conclusion that a "solomonic apportionment of liability" is appropriate. *Winstead,* 855 F.2d at 434. Such a result may be, as *Winstead* suggests, "eminently fair," but it accords insufficient weight to the policy consideration behind the enactment of ERISA. Our situation is unlike the one where the competition is between COB clauses in nonqualifying private insurance policies. There, the playing field is level; here it is not, since the TAV clause is bolstered by the preemptive effect of ERISA.

Accordingly, we conclude that the terms of the TAV plan, including its coordination of benefits clause, must be given full effect in order to comply with a primary goal of ERISA, which is

to safeguard the financial integrity of qualified plans by shielding them from unanticipated claims.

III.

For the foregoing reasons, the judgment of the district court is **reversed** and this cause is **remanded** with instructions that judgment be entered in favor of defendant, Thorn Apple Valley, Inc.

Appendix B

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No: 93-1606

AUTO OWNERS INSURANCE COMPANY, a Michigan Insurance Corporation,

Plaintiff-Appellee,

v.

THORN APPLE VALLEY, INC.,

Defendant-Appellant.

Before: **Norris** and **Daughtrey,** Circuit Judges; and **Gilmore,** Senior District Judge.

JUDGMENT

ON APPEAL from the United States District Court for the Western District of Michigan at Grand Rapids.

THIS CAUSE was heard on the record from the district court and was argued by counsel.

ON CONSIDERATION WHEREOF, it is ORDERED that the judgment of the district court is REVERSED and the cause is REMANDED with instructions that judgment be entered in favor of defendant, Thorn Apple Valley, Inc.

ENTERED BY ORDER OF THE COURT
s/ Leonard Green
Leonard Green, Clerk.

Appendix B

A True Copy.

Attest:

Deputy Clerk

Issued as Mandate: 11-04-94

COSTS: NONE

Filing Fee .....$
Printing .....$

Total .....$

APPENDIX C — OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF MICHIGAN, SOUTHERN DIVISION DATED APRIL 12, 1993

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

File No. 1:92-CV-583

HON. ROBERT HOLMES BELL

AUTO-OWNERS INSURANCE COMPANY,

Plaintiff,

v.

THORN APPLE VALLEY and CHRIS L. SHATTUCK,

Defendants.

OPINION

In this ERISA[1] case involving a sponsor of a self-funded employee welfare benefit plan and a Michigan no-fault insurer, two conflicting "other insurance" or coordination of benefits provisions are presented. The question—which appears to be one of first impression in this Circuit—is which party, under federal common law, is primarily liable for coverage of a car accident injury claim in such a case. Concluding that the primary liability

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1. The Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461.

must be shared on a *pro rata* basis by the insuring parties, the ERISA plan sponsor's motion for dismissal/summary judgment is DENIED and the no-fault insurer's cross-motion for summary judgment is GRANTED.

I.

A.

The facts are not in serious dispute. Chris Shattuck ("Shattuck"), a minor, was injured in a motor vehicle accident on June 18, 1989. His injuries required medical attention.

Shattuck had two insurers for his medical expenses: Auto-Owners Insurance Company ("Auto-Owners"), his father's Michigan no-fault insurance carrier; and his father's self-funded employee welfare benefit plan sponsored by Thorn Apple Valley ("Thorn Apple"). Both Auto-Owners' no-fault policy and Thorn Apple's ERISA plan contained an unambiguous, valid, and irreconcilable "other insurance" or a coordination of benefit provision, which effectively placed the other insurer primarily liable for expenses arising out of car accident injuries.

Auto-Owners initially paid the medical expenses related to Shattuck's injuries. Subsequently, Shattuck's father submitted claims for medical benefits related to Shattuck's injuries to Thorn Apple's ERISA plan.

Thorn Apple's ERISA plan denied Shattuck's father's claims. It relied on its coordination of benefits provision contained in its ERISA plan. This denial, in turn, caused Auto-Owners to commence this action.

Appendix C

B.

The complaint was first filed in the Ionia County Circuit Court in Michigan. It was then removed to this Court on August 24, 1992.

In the complaint, Auto-Owners seeks to "recoup" from Thorn Apple all amounts which Auto-Owners has paid for medical benefits on behalf of Shattuck. It also requests a declaration that Thorn Apple, not Auto-Owners, is primarily liable for any of Shattuck's future automobile accident related medical expenses. Auto-Owners alleges that under its required coordination of benefits provision in its no-fault policy, *see* Mich. Comp. Laws § 500.3109a, which is in conflict with Thorn Apple's ERISA plan's coordination of benefits provision, it is entitled to recoupment of past expenses from Thorn Apple and a declaration of secondary liability for Shattuck's future expenses. *See Federal Kemper Ins. Co. v. Health Ins. Administration, Inc.*, 424 Mich. 537 (1986).

In response, Thorn Apple moves for dismissal under Fed. R. Civ. P. 12(b)(6) and/or summary judgment under Rule 56. Auto-Owners opposes Thorn Apple's motion and requests entry of summary judgment in its favor instead.[2]

II.

Thorn Apple advances two principal arguments in support of its motion. First, Thorn Apple contends that Auto-Owners' state law no-fault claim is preempted by ERISA. Second, Thorn Apple

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2. This Court construes Auto-Owners's request as a cross-motion for summary judgment.

argues that once there is a finding of ERISA preemption, federal law provides no further remedy for Auto-Owners. In short, Thorn Apple's position is that the ERISA preemption analysis is the only required substantive inquiry to resolve this coverage dispute involving conflicting "other insurance" or coordination of benefits provisions.

Auto-Owners, on the other hand, suggests that the inquiry is so straightforward. While conceding—at oral argument—that ERISA preempts Michigan's no-fault statute, Auto-Owners asserts that the real analysis only begins once that preemption finding is made; that under the recent Sixth Circuit law, courts must fashion an appropriate rule under federal common law of ERISA after finding that federal law governs a coverage dispute involving competing "other insurance" or coordination of benefits provisions contained in an ERISA plan and a no-fault insurance policy. And in fashioning such a federal rule, Auto-Owners urges this Court to adopt an approach taken by another federal circuit.

A.

This Court's analysis must, of course, begin with the applicable standard of review. Because matters outside the pleadings have been considered in evaluating the parties' motions, this Court must treat the motions as ones for summary judgment, and apply the standard for summary judgment. *See* Fed. R. Civ. P. 12(b); *Friedman v. United States*, 927 F.2d 259, 261 (6th Cir. 1991).

Rule 56 provides the compass for evaluating summary judgment motions. It states that summary judgment is appropriate only if "there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter

of law." Fed. R. Civ. P. 56; *Guarino v. Brookfield Township Trustees*, 980 F.2d 399, 403 (6th Cir. 1992).

After careful review, there appears to be no genuine issue as to any material fact in this case. Except for one additional ERISA plan document submitted by Thorn Apple in support of its motion, both parties rely on the same alleged facts in the complaint. And the parties' almost exclusive focus on the two legal questions, the applicability of ERISA preemption and the availability of federal common law rule, only confirms the belief that there are no triable issues of fact at hand.

B.

This Court must then turn to the legal questions. Although two legal questions were originally presented by the parties, only one requires extended discussion now.

(1).

The first question, whether Auto-Owners's state law no-fault claim of recoupment is preempted by ERISA, is all but settled. In its initial responsive brief[3] to Thorn Apple's motion, Auto-Owners implicitly acknowledges that its state law no-fault claim is preempted by ERISA. *See* Auto-Owners Memorandum of Law at 8. And at oral argument, Auto-Owners, in response to this Court's inquiry, expressly conceded that preemption. Finally, no mention is made of ERISA preemption in Auto Owners's supplemental brief. *See* Plaintiff's Response to Supplemental Brief in Support of Defendant's Motion to Dismiss and/or for Summary Judgment.

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3. The parties have filed supplemental briefs during the pendency of the instant motions.

Of course, even if Auto-Owners had not acquiesced on Thorn Apple's preemption argument, it would not have been successful. The prevailing Sixth Circuit law—consistent with the Supreme Court's teaching in *FMC Corp. v. Holliday*, __ U.S. __, 111 S. Ct. 403, 112 L. Ed. 2d 356 (1990)—holds that where, as here, state law—such as the Michigan No-Fault Insurance Act, Mich. Comp. Laws § 500.3100 *et seq.*—relates to an ERISA plan, the federal law of ERISA preempts that state law. *Lincoln Mutual Casualty Co. v. Lectron Products, Inc., Employee Health Ben. Plan*, 970 F.2d 206, 209-210 (6th Cir. 1992); *Auto Club Ins. Ass'n v. Health and Welfare Plans, Inc.*, 961 F.2d 588, 592-93 (6th Cir. 1992). Therefore, Auto-Owners's no-fault claim based on Michigan law is no longer viable in light of ERISA preemption.

(2).

But that does not end the matter. Because ERISA preemption does not resolve the coverage dispute, but merely suggests that federal law, instead of state law, governs the dispute, *see Lincoln Mutual*, 970 F.2d at 210-11; *Slice v. Norway*, 978 F.2d 1045, 1046 (8th Cir. 1992), this Court must next turn to the second question: what federal law resolves the dispute here.

(i).

To begin, the ERISA statute itself does not provide an answer. Nothing in the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461, addresses an "other insurance" or a coordination of benefits provision that may contain in an insurance policy. *Lincoln Mutual*, 970 F.2d at 211; *see also PM Group Life Ins. Co. v. Western Growers Assur. Trust*, 953 F.2d 543, 546 (9th Cir. 1992) (Kozinski, J.) (noting that ERISA does not provide a coordination of benefits provision to resolve conflicts between two ERISA plans). Accordingly, there is no

statutory ERISA rule that this Court can readily apply to resolve the dispute here.

In enacting the ERISA statute, however, Congress anticipated this sort of a problem. Its legislative history indicates that Congress foresaw occasions where there would be gaps left in the express provisions of ERISA, *see Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496, 1499 (9th Cir. 1984), and in such occasions, Congress intended courts to fill the interstices by developing federal common law of ERISA. *See* 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987)); *see also Kwatcher v. Massachusetts Serv. Employees Pension Fund*, 879 F.2d 957, 966 (1st Cir. 1989).

To be sure, the Sixth Circuit has heeded this legislative directive by repeatedly recognizing the need to develop federal common law to address various issues involving rights and obligations under an ERISA plan. *See, e.g., Whitworth Bros. Storage Co. v. Central States, Southeast & Southwest Areas Pension Fund*, 982 F.2d 1006 (6th Cir. 1993) (reviewing under federal common law whether a contractual limitation on refunds for contributions mistakenly made is unreasonable); *Flacche v. Sun Life Assur. Co.*, 958 F.2d 730 (6th Cir. 1992) (declining to review the definition of the term fiduciary under federal common law because the ERISA statute already expressly addresses the term); *Armistead v. Vernitron Corp.*, 944 F.2d 1287 (6th Cir. 1991) (reviewing the doctrine of equitable estoppel under the Circuit's established federal common law).

In fact, the Sixth Circuit has specifically recognized that federal common law of ERISA must be developed to address the

central question in this case, namely, what coverage priority rule should apply in a case where there are two competing "other insurance" or coordination of benefits provisions. *See Lincoln Mutual Casualty Co. v. Lectron Products, Inc., Employee Health Ben. Plan*, 970 F.2d 206, 211 (6th Cir. 1992); *Auto Club Ins. Ass'n v. Health and Welfare Plans, Inc.*, 961 F.2d 588, 594-95 (6th Cir. 1992).[4]

(ii).

In formulating a federal common law rule for evaluating a coverage priority question, this Court may review state law approaches, particularly because "states generally having had much more experience in the area of insurance contract interpretation." *Wickman v. Northwestern Nat'l Ins. Co.*, 908 F.2d 1077, 1084 (1st Cir.), *cert. denied*, 498 U.S. 1013 (1990); *see also Phillips v. Lincoln Nat'l Life Ins. Co.*, 978 F.2d 302, 311 (7th Cir. 1992) (in making federal common law rules, it is "proper to turn to state law when creating such rules, . . . as long as such state law is consistent with the policies underlying the federal statute at issue").

Two principal state law approaches have emerged. The Michigan Supreme Court has distinguished them as majority and minority views in *Federal Kemper Ins. Co. v. Health Ins. Administration, Inc.*, 424 Mich. 537 (1986):

> The majority rule attempts to reconcile the competing provisions by discerning the parties' intent through an analysis of the clauses. Critics of this approach argue that it

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4. Despite this suggestion by the Sixth Circuit, it appears that no district court in this Circuit (or elsewhere) has yet developed a federal common law rule that is applicable here.

> is circular and that the decision as to which clause is primary depends on which policy is read first. Thus some courts deem the provisions "mutually repugnant" and reject both clauses. Courts adopting this minority view . . . hold that liability must be prorated.

Id. at 543 (citations omitted); *see, generally* 8A Appleman, *Insurance Law and Practice* §§ 4907.65-4909 (1981).

The Michigan Supreme Court has not endorsed either approach. Rather, the Michigan Supreme Court has staked a different position by formulating a special rule mandating that when a no-fault insurance policy and a health insurance policy contain conflicting coordinated benefits provisions, the health insurance carrier will be primarily liable for the insured's medical expenses resulting from injuries suffered in a motor vehicle accident. *Federal Kemper*, 424 Mich. at 551.

In reviewing which of the foregoing approaches might be suitable here, however, this Court does not have a clean slate. In *Auto Club Insurance Association v. Health and Welfare Plans, Inc.*, 961 F.2d 588 (6th Cir. 1992), the Sixth Circuit, addressing similar circumstances as here, suggested an approach that a district court may consider. The Sixth Circuit indicated, without expressly mandating, that in developing federal common law to resolve a conflict in two coordination of benefits provisions, the district court should review the Seventh Circuit's decision in *Winstead v. Indiana Insurance Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, 488 U.S. 1030 (1989).[5]

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5. The Sixth Circuit repeated this suggestion by approvingly citing *Winstead* in a later decision addressing the same issue. *See Lincoln Mutual Casualty Co. v. Lectron Products, Inc., Employee Health Ben. Plan*, 970 F.2d 206, 211 (6th Cir. 1992).

Appendix C

In *Winstead*, the Seventh Circuit was confronted with an ERISA plan and a non-ERISA automobile insurance policy governed by Michigan's no-fault insurance law.[6] Both the ERISA plan and the non-ERISA insurance policy contained a coordination of benefits provisions. In resolving the conflict between the two provisions to determine primary coverage liability, the Seventh Circuit endorsed the district court's ruling that, based on federal common law, the liability between the ERISA plan and the non-ERISA insurer should be apportioned on a *pro rata* basis. The Seventh Circuit further explained that:

> Application by the district court in this case of such a solomonic apportionment of liability is not only in keeping with generally accepted notions derived from state common law, [citing insurance law treatises], but seems eminently fair and equitable.

Winstead, 855 F.2d at 434.

After careful review, this Court agrees with the *Winstead* approach—which is the minority state law approach in apportioning liability—in resolving a conflict in "other insurance" or coordination of benefits provisions. Besides the reasons already stated by the Seventh Circuit, this *pro rata* approach, as a federal common law rule, is a simple one to apply. *See cf. Edelmann v. Chase Manhattan Bank N.A.*, 861 F.2d 1291,

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6. Although *Winstead* preceded the Supreme Court decisions in *FMC Corp. v. Holliday*, __ U.S. __, 111 S. Ct. 403, 112 L. Ed. 2d 356 (1990), and *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Sixth Circuit found that those Supreme Court decisions did not affect *Winstead*. *See Auto Club*, 961 F.2d at 595 n. 14. And this Court's research discloses no Seventh Circuit decision repudiating or criticizing *Winstead*.

1301 n. 63 (lst Cir. 1988) (Wisdom, J., sitting by designation) ("A simple rule promotes predictability, certainty, and uniformity from case to case."). And adopting this approach, of course, promotes national uniformity, since another federal court has previously done so. *See PM Group Life,* 953 F.2d at 548. Finally, the *pro rata* approach, which provides coverage under an ERISA plan, is consistent with the purpose of ERISA of "protecting the interests of Plan members and their beneficiaries." *Luby v. Teamsters Health, Welfare, & Pension Trust Funds,* 944 F.2d 1176, 1187 (3d Cir. 1991).

Accordingly, this Court adopts the following rule as the appropriate coordination of benefits rule under ERISA: When there is a conflict between two unambiguous, valid, and irreconcilable "other insurance" or coordination of benefits provisions in an ERISA plan and a non-ERISA insurer, such as a Michigan no-fault insurer, the coverage responsibility must be apportioned between the insurers on a *pro rata* basis.

(iii).

Applying the *pro rata* rule here, this Court finds that the primary liability for Shattuck's medical expenses, including the future expenses, related to the automobile accident must be shared on a *pro rata* basis (50 percent each) by Auto-Owners and Thorn Apple, the two insuring parties. Thorn Apple's argument to the contrary is therefore rejected.

(3).

Having so concluded, this Court turns to Thorn Apple's other arguments. Two are worthy of brief discussion: (1) Thorn Apple asserts that this Court need not address any of the issues in this

case for lack of exhaustion of internal administrative remedies; and (2) Thorn Apple claims that there is no "real" conflict between the two coordination of benefits provisions.

This Court disagrees with both contentions. First, the exhaustion requirement is applicable when a participant or a beneficiary of an ERISA plan is challenging the Plan's denial of a benefit claim. *See Baxter v. C.A. Muer Corp.*, 941 F. 2d 451, 453-54 (6th Cir. 1991). It is not applicable where, as here, declaratory judgment and recoupment action—not a claim for benefits under ERISA—is brought by a non-participant or a non-beneficiary of an ERISA plan.

Second, Thorn Apple's argument regarding the characterization of the two coordination of benefits provisions in question—an argument mentioned in passing—was heard, considered, and rejected by the Michigan Supreme Court in *Federal Kemper, See* 424 Mich. at 542-44; *see also Auto-Owners Insurance Co. v. Lacks Industries*, 156 Mich. App. 837, 839-40 (1986) (rejecting a similar argument on the basis of *Federal Kemper*). There is no need to further discuss what the Michigan Supreme Court has already carefully explained.

III.

For the reasons stated above, Thorn Apple Valley's motion for dismissal or summary judgment is DENIED and Auto-Owners Insurance Company's cross-motion for summary judgment is GRANTED. An order consistent with this opinion shall issue forthwith.

Dated: April 12, 1993

s/ Robert Holmes Bell
ROBERT HOLMES BELL
UNITED STATES DISTRICT JUDGE

Appendix C

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

File No. 1:92-CV-583

HON. ROBERT HOLMES BELL

AUTO-OWNERS INSURANCE COMPANY,

Plaintiff,

v.

THORN APPLE VALLEY and CHRIS L. SHATTUCK,

Defendants.

ORDER

In accordance with the opinion entered this date;

Thorn Apple Valley's motion for dismissal or summary judgment is DENIED and Auto-Owners Insurance Company's cross-motion for summary judgment is GRANTED.

IT IS SO ORDERED.

Dated: April 12, 1993

s/ Robert Holmes Bell
ROBERT HOLMES BELL
UNITED STATES DISTRICT JUDGE